STAMFORD HOSPITAL

DPH Plan of Correction - December 27, 2018

Approved 1/9/19 SHN

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (d) Medical Records (2) and/or (e) Nursing Service (1) and/or (i) General (6).				
1. Based on clinical record review, interview and policy review for 2 of 3 dialysis patients reviewed (Patients #13 and 20) the facility failed to ensure that that the dialysis was administered as ordered. The findings include the following: a. Review of Patient #20's clinical record on 8/28/18 at 10:00 AM with the Manager indicated that the patient was a hemodialysis patient. The physician's orders dated 8/6/18 directed hemodialysis for 3 hours to be administered with a blood flow rate (BFR) of 400 ml/min and a dialysis flow rate (DFR) 600 ml/min. Review of the hemodialysis flow sheet dated 8/6/18 indicated that the delivered BFR was 250 ml/min and DFR was 500 ml/min. The record failed to reflect the rationale for not administering the prescribed BFR/DFR.	On 9/12/18, all Dialysis Registered Nurses were reeducated that any deviation from prescribed BFR/DFR must have rationale and order change from physician. MD must enter order in electronic medical record. Work group created to develop meaningful order sets for dialysis. Implemented 10/1/18. Go live 1/1/2019.	Director of Quality, Patient Care Services	9/12/18 1/1/2019	• On 9/1/2018, the Manager, Dialysis began weekly monitoring of patient dialysis orders, BFR/DFR and dialysis documentation on the flow sheet to ensure that any treatment changes are directed by physician orders. • Weekly audits will continue until December 31, 2018 and then the audits will be done monthly. • Results of the BFR/DFR monitoring have shown 100% compliance.

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b. Review of the clinical record for Patient #13 indicated that the patient was receiving hemodialysis. Review of the physician's orders dated 8/10/18 directed Heparin 500 units per hour and 1,000 units Heparin at the start of treatment. Review of the hemodialysis record dated 8/10/18 failed to reflect that the Heparin had been administered. Review of the medication administration record with the Dialysis Manager on 8/30/18 at 11:00 AM indicated that the Heparin was "held per MD order" however the record failed to reflect the presence of an order. Review of the dialysis policy indicated that all orders must originate with the physician. Orders are required for any services billed.	On 9/12/2018, all Dialysis Registered Nurses were reeducated that any deviation from ordered heparin administration must have an order entered by the physician in electronic medical record. A work group was created to develop comprehensive order sets for dialysis. Implemented 10/1/18. Go live 1/1/2019		9/12/18 1/1/2019	• Results of the audits are being reported out at the monthly Dialysis Quality meetings. • On 9/1/2018, the Manager, Dialysis began weekly monitoring of patient dialysis heparin orders to ensure they correspond to dialysis flow sheet- heparin administration • Weekly audits will continue until December 31, 2018, and then the audits will be done monthly. • Results of the audits are being reported out at the monthly Dialysis Quality meetings.

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2. Based on review of facility documentation, policy review and interview the facility failed to ensure that water testing was completed appropriately and/or that chloramine levels were monitored appropriately. The findings include the following:	On 9/12/18, All Dialysis Registered Nurses were reeducated regarding requirement to document actual value observed on the test strip. Documentation of the less than sign is not acceptable.	Nursing Director of Quality, Patient Care Services	9/12/18	
a. Review of the Chlorine/Chloramine monitoring flow sheets with the Manager, Dialysis on 8/29/18 at 2:00 PM for March 2018 indicated that for the total chlorine test the identified result was "y" with the goal being <0.1 mg/ml. The records failed to reflect the presence of the actual value observed on the test strip. The Manager indicated that she had identified that as a problem and reeducated staff.	Nurses were also reeducated that the test strip should be submerged in water and that after 20 second wait period immediately compare the strip color to the color chart to determine the total chlorine level in the sample.	Nursing Director of Quality, Patient Care Services	9/12/18	
b. Review of the RO operation log sheets for March 2018 indicated that for chlorine testing the result identified was				

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<0.09 mg/ml. However, review of the test strips with the Manager indicated that test strips utilized had identified color readings of 0.01 mg/ml, 0.02 mg/ml, 0.05 mg/ml and 0.1 mg/ml. The record failed to reflect the actual reading. Review of the policy indicated that the test strip should be submerged in water and that after 20 second wait period immediately compare the strip color to the color chart to determine the total chlorine level in the sample.				
c. Review of the AAMI (Association for the Advancement of Medical Instrumentation) testing documentation with the Dialysis Manager on 8/30/18 at 10:00 AM for July of 2018 indicated that AAMI testing was completed on the 5 portable reverse osmosis machines in the facility however the records failed to reflect that a tap water sample had been obtained at that time for comparison to ensure that the water treatment components removed all contaminants.	On 9/12/18, All Dialysis Registered Nurses and the Dialysis Technician were reeducated on the daily and monthly required routine monitoring process for all machines and that the AAMI maintenance documentation needs to be complete.	Nursing Director of Quality, Patient Care Services	9/12/18	• Weekly review of the AAMI testing and documentation began on 10/1/18 to ensure that the tap water sample has been obtained for comparison and that the documentation is complete. • Results of the audits have shown 100% compliance. • Results of the log review will be reported out at

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				the monthly Dialysis Quality meeting.

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The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (e) Nursing Service (1) and/or (i) General (6). 3. Based on clinical record review, and interview for one patient with suicidal ideation (Patient #19) the facility failed to ensure that a suicide risk assessment was completed. The findings include the following: a. Patient #19 presented to the ED on 8/27/18 at 6:26 PM after a suicide attempt. Review of the record with the Assistant Nurse Manager on 8/28/18 at 10:00 AM Indicated that the patient was brought in by police after throwing self in front of a car. The triage note indicated that the patient denied suicidal ideation and the patient was placed on a one to one. The record failed to reflect that further suicide risk assessments (SRA) had been completed. The Assistant Nurse Manager indicated that SRA's should be completed each shift and the physician should be notified based on the score.	All Emergency Department nurses were reeducated on the suicide risk assessment and the requirement that it must be completed every shift and to notify the physician if indicated. The suicide risk assessment requirements were reviewed at the October 24, 2018 staff meeting. Create practice alert with review of suicide documentation.	Nurse Educator - Emergency Department Nurse Educator - Emergency Department Nurse Educator - Emergency Department	Education began 10/2018 and will be completed by 1/31/2019. 10/24/2018 10/24/2018-1/9/32019	• The Emergency Department Educatory will audit 5 charts for three consecutive months to ensure compliance with timely suicide risk assessments and physician notification if indicated. • The results of the audits will be shared at the monthly Emergency Department Staff Meetings.

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4. *Based on clinical record review, interview and policy review for 1 of 3 patients reviewed that a nerve block (Patient #21) the facility failed to ensure that the block was completed on the correct site. The findings include: a. Patient #21 presented to same day surgery on 12/14/16 for a right foot bunionectomy. The note indicated that a single nerve block was requested by the surgeon for analgesia. The anesthesia addendum dated 12/16/16 at 10:07 PM indicated that a popliteal and saphenous nerve blocks were indicated for this procedure. The note indicated that a time out was performed, the patient was in a prone position, the right leg was marked and right popliteal nerve block was performed. The patient was then placed in a supine	Event debrief and staff huddles Policy review and revision to capture the requirement to have 2 separate documented time outs for blocks that require 2 separate injections. A memo was sent from the Chair, Dept. of Anesthesia to anesthesia providers to inform them of the event and the policy requirement for a separate time-out for each block injection and the need for individual site marking for each block injection site. Review of nursing documentation of anesthesia	Clinical Operations Director and Nurse Educator Chair, Department of Anesthesia Nurse Educator	12/15/2016-12/19/2016 12/18/2016 12/18/2016 12/21/18	• Direct Observational Audits: • Ten (10) observational audits for three months were completed. • After three (3) months 10 observational audits per quarter were completed for three (3) quarters. • Results of the audits showed 100% compliance and were reported out at the OR Committee Meeting.

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position and the saphenous nerve block was performed on the left side in error. The nurse's note (RN #3) dated 12/15/16 at 9:50 AM Indicated that the patient underwent a right popliteal block without difficulty, the patient then received a saphenous vein block on the non-operative leg. MD #2 made aware after the patient indicated that the leg was numb on the opposite side of where surgery was completed. Interview with RN #3 on 8/30/18 at 1:20 PM indicated that patient was initially placed face down for the popliteal block and once completed she left the area to gather more supplies for the saphenous block and on return to the area the patient had turned face up and the saphenous block was completed. A short time later the patient asked why the block was placed on the opposite leg from where surgery was completed. Interview with the Chief of Anesthesiology on 8/30/18 at 1:40 PM indicated that on review of the case it was determined that MD #2 had marked the area of the popliteal block but not the saphenous block. The Chief of Anesthesiology	blocks to support documenting process of separate time outs for each injection. Addition to the intraoperative record-preemptively to ensure compliance with block time out documentation in the operative record. A memo was sent from the Executive Director, Perioperative Services to all preoperative staff regarding nursing roles during block and the requirement for a time out before <u>each</u> block.	Nurse Educator Clinical Operations Director	12/21/2018 12/28/2016	

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indicated that the policy was to mark the area prior to the procedure. Review of the facility procedure indicated that the attending surgeon, proceduralist or anesthesiologist at time of Anesthesia Block identifies the operative or procedural site and marks the site with his/her initials using a special permanent marker provided by the pre-op nurse or procedural assistant. The mark must be placed over, or as close to the surgical/procedural site as practical, in a manner so that it will be visible after the patient is prepped and draped. Multiple digits will be marked individually.				

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of the penis and xeroform with a foam barrier was applied. The patient had wound care consultation completed on 12/27/16 that indicated that the wound was a stage 3 and measured 0.5 by 3.1 by 0.1. The note indicated that the patient had a full thickness wound on the proximal shaft of the penis consistent with a device related stage III pressure injury. Review of the policy indicated that a comprehensive skin assessment should be completed as least once every twelve hours. The policy indicated that this includes removing the patient's socks to assess feet and assessing skin beneath all medical devices.				

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9/3/18 at 4:15 PM through 9/4/18 at 1:20 AM. Interview and review of the labor and delivery flow sheet with Nurse Manager #1 on 9/4/18 at 1:00 PM identified maternal and fetal assessments failed to be conducted on six occasions from 5:15 PM through 9:00 PM. Maternal assessments included the frequency, duration, quality and pattern of the contraction in addition to the resting tone of the uterus. The fetal assessment included the baseline fetal heartrate, variability, the presence of fetal accelerations and/or decelerations. Further interview with Nurse Manager #1 indicated it was the policy of the hospital to conduct maternal and fetal assessments every half hour when a patient met the criteria for a high-risk pregnancy. The hospital policy entitled Fetal Monitoring directed in part, that fetal monitoring was required upon arrival to labor and delivery. For high risk patients, which included any hypertensive disorder, maternal and fetal assessments should be conducted every thirty minutes.				

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7. Based on a clinical record review, staff interviews and a review of the hospital's policies and procedures for one of two sampled patients (Patient #38), the hospital failed follow the bereavement procedure for a fetal loss to ensure that an autopsy was conducted timely and in accordance with the hospital's policies and procedures. The finding included: a. Patient #38 was admitted to the hospital on 7/26/17 for an induction of labor for a known fetal demise at thirty-one weeks' gestation. Patient #3 was delivered on 7/28/17. Interview with Nurse Manager #1 on 9/5/18 at 12:00 PM indicated Patient #3 was sent to the funeral home	Review of bereavement processes during Safety Huddles. Demise chart audits have been created to monitor and to ensure compliance with process and policy.	Nurse Manager Labor & Delivery	9/2018 and 10/2018	• Audit one fetal demise with autopsy record per month for three consecutive months to ensure the process is being followed for autopsies. • Results of the audits will be reported out at the monthly Labor and Delivery staff meetings

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absent an autopsy that was requested by the family. The funeral director notified the family when preparing the body as they had identified an autopsy was not conducted. Further interview with Nurse Manager #1 indicated the family called the hospital to inform them of the error. The hospital picked up the infant from the funeral home and conducted the autopsy. Nurse Manager #1 identified RN #4 had completed her shift on 7/28/17 and failed to communicate to RN #5, who was the oncoming nurse, what needed to be completed on the perinatal bereavement checklist. Nurse manager #1 indicated RN #4 and RN #5 failed to notify pathology that an autopsy was requested, and failed to attach the paperwork to the outside of the sheet that the infant was swaddled in identifying an autopsy was requested. The paperwork was found wrapped inside of the sheet and was not visible to the hospital staff alerting them to conduct the autopsy. Further interview with Nurse				

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Manager #1 indicated the nursing staff did not follow the policy and/or perinatal bereavement checklist and should have. The hospital policy entitled fetal loss directed in part, that an infant at twenty weeks or greater would have a release and disposition of body form completed, a request for permission to perform an autopsy and a request for genetic testing. The on-call pathologist and medical examiner would be notified. A bereavement checklist would be completed by the Registered Nurse caring for the patient. A copy of the disposition form, permission for the autopsy and death certificate along with a copy of the bereavement checklist would be sent to the registrar. The body would be wrapped with completed morgue tags in a white sheet and pathology would be notified that the body was in the morgue.				

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was identified that a surgical pin was not removed from the C7 level. It was identified that there were vendor trays with instruments used during this case and the vendor instruments were not included in the surgical counts and should have been. As a result, policies and procedures were updated to include vendor trays used during surgical procedures and staff and surgeons were re-educated.	Joint Memorandum and Practice Alert sent from Chair, Department of Surgery, Chair, Department of Radiology and Executive Director of Perioperative Services with the Immediate Action Plan for radiologic confirmation of retained surgical instrumentation.	Executive Director and Chair of Surgery Executive Director, Nurse Educator	6/6/2018	
	An educational review of instrument counting expectations and requirements was completed with all RNs and Surgical Techs.	Executive Director, Nurse Educator	6/7/2018	
	Additional Staff Education			
	Huddle Discussions.	Executive Director, Nurse Educator	6/6/2018, 6/7/2018, ongoing	
	Review of count practices.		6/7/2018	
	Situational Awareness and Count Practices Quarterly Meeting.		6/14/2018	

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b. Patient #36 underwent a transobturator tape placement and cystoscopy on 4/17/18. At the conclusion of the surgery a urinary catheter was inserted and vaginal packing was placed. The presence of the packing was not documented in the clinical record and was not communicated to staff during hand off to the PACU staff. Review of the clinical record and review of the hospital's documentation of the case identified that while the patient was in the PACU, the surgeon requested that a Chief Resident perform a voiding trial and remove the urinary catheter packing. At the request of the Chief Resident the voiding trial was conducted by an Intern and the urinary catheter was removed. However, the vaginal packing was not removed. After being discharged home, Patient #36 removed the vaginal packing. Review of the clinical record, review of hospital documentation and interview with MD #5 on 9/12/18 at 12:45 PM identified that he instructed the Resident to remove the vaginal packing when the urinary catheter was removed. According to hospital documentation, there was miscommunication between	On-line learning module count practices Nurses/Techs. Annual Update Day RN/Techs. RCA Completed. Joint Memorandum was sent by Chair of OB/GYN and the Executive Director of Surgical Services. The Operative Record was revised to better capture dressing with wound packing and now includes:	 RCA Team Executive Director, Chair OB/GYN Executive Director, Nurse Educator	6/19/2018 3/2019-6/2019 4/17/2018 4/20/2018 4/20/2018	

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the Chief Resident and surgeon regarding the presence of packing and that it was to be removed. Following this incident, all surgical services providers were instructed to document the presence of vaginal packing in the operative note, enter orders for vaginal packing removal, and communicate the presence of packing during patient hand-off.	packing type, size, and location. The Director of Clinical Operations sent a practice alert to the clinical nursing and surgical tech staff highlighting instructions for documenting wound packing in the revised operative record and the inclusion of packing intentionally left in place during hand off communication. Education was provided to the Surgical department, including surgeons who utilize post-op packing, to ensure that the tail of the packing is externally visible and that the use of packing has been communicated to all relevant staff. A policy was developed to focus on the hand-off process and procedure for	Clinical Operations Director Nurse Educator Executive Director, Nurse Educator	4/23/2018 9/15/2018 10/2018-12/2018	• Ten observational audits per month, measuring compliance with packing documentation and hand off communication when wound packing is used, are ongoing. • Results of the audits are being reported out at the OR Committee.

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	Surgeons when wound packing is used. Surgeons and residents were reeducated at the Department Business meetings regarding the new Hand-off Policy.		1/2019 – 2/2019	

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The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2). 9. Based on clinical record review, facility documentation and interviews for one patient who was discharged from an outpatient department (Patient #37), the facility failed to ensure the patient was offered a discharge plan and/or an alternative treatment venue. The findings include: a. Patient #37 was scheduled for an outpatient appointment in the hospital's sleep center on 5/23/12. The patient's diagnoses included sleep apnea and Bipolar disorder. The sleep center physician progress notes dated 5/23/12 identified Patient #37 was examined, a prescription for Provigil tablet given and plan for return in 6 - 8 weeks to monitor his/her progress. In addition, the progress note identified the patient had on his person a loaded gun and had threatened the office staff when he/she was asked to be weighed; security was called and the incident ended peacefully.	Stamford Hospital respectfully disagrees with the findings of this violation due to the following: The patient in question was not a patient of Stamford Hospital, but was seeing a Private Practice Group physician, who was not practicing under the Hospital's license, in office space on the Hospital campus. The Private Practice Group was billing for services under their own tax and provider identification number. Upon the Private Practice patient's threat of violence towards an employee of the Private Practice Group and the finding of a loaded weapon upon the patient, the patient was disarmed and	Director, Safety and Security Director, Safety and Security	5/23/2012 6/5/2012	

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Facility documentation identified a letter dated 6/4/12, addressed to Patient #37 informed him/her that he/she was prohibited from entering the grounds of the hospital and its affiliated properties for any purpose other than to obtain emergency care in the Emergency Department. The letter also identified if Patient #37 violated the conditions, he/she would be escorted off the premises. Review of facility documentation failed to identify Patient #37 was offered alternative venues to follow up on the treatment plan. In an interview on 9/5/18 at 10:35AM, Security Specialist #1 identified the sleep center nurse had noticed Patient #37 was acting oddly, upon asking to be weighed the patient refused and implied that he/she had a gun and did not want to hurt the nurse. Security Specialist #1 identified he was called to the sleep center and spoke to Patient #37 who gave him the gun upon asking and immediately removed the bullets. Security Specialist #1 further identified the police were called and the patient was taken into custody.	escorted off the property by Stamford Police. A letter was sent by Stamford Hospital's Director, Safety and Security, who is responsible for oversight of security on the Hospital campus, stating that, due to threatening behavior and the carrying of a firearm into the Private Practice Group's physician's office, located on the Stamford Hospital campus, the patient was prohibited from Hospital grounds but would continue to have access to emergency care. The letter stated that should the patient have questions, to please contact Stamford Hospital's Director, Safety and Security. The Private Practice Group responsible for the treatment of the patient was sent a letter by Stamford Hospital, providing recommended communication to the patient. The communication stated that the patient should seek care	Risk Management	6/2012	

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Review of the facility Patient Conduct policy identifies in part discharge planning obligations; patients that act inappropriate must still be provided discharge planning if medically necessary.	with a new provider for ongoing treatment and that upon doing so, the Private Practice Group would be happy to provide the patient and the new provider with the patients' medical records free of charge. The Hospital did not have a treating relationship with the patient at the time of this occurrence and the Hospital provided guidance to the private physician office to ensure ongoing care for the patient.			

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(acceptable range 35%-60%) for 23 of the 31 days, the buffer room was greater than 60% for 10 of the 31 days, and the chemo room was greater than 60% for 15 of the 31 days. The log failed to indicate that Pharmacy staff notified the Facilities Management Department of the elevated humidity levels. b. Review of the Cancer Center Pharmacy IV Room Temperature and Humidity Log during the period of 8/1/18 through 8/30/18 identified that humidity levels in the anteroom was greater than 60% (35%-60%) for 11 of the 22 days in which readings were documented and the buffer room was greater than 60% for 17 of the 21 days. The log failed to indicate that Pharmacy staff consistently notified the Facilities Management Department of the elevated humidity levels (notification documented on 8/3, 8/7, 8/17, 8/29, and 8/30/18). Review of the IV logs and interview with the Interim Pharmacy Director on 8/30/18 at 11 AM stated elevated humidity levels have been an issue on and off for months and Facilities was aware. The Interim Pharmacy Director further identified that staff should notify Facilities and documents the notification	Main Pharmacy air handler automation and controls upgrade scheduled for Q1 2019.			

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of the humidity log if the humidity level is less than 35% or greater than 60%. Review of the humidity logs and general maintenance-verbal work orders for the same period of time with the Director of Facilities Management and the Executive Director on 8/30/18 at 1PM stated elevated humidity levels have been an issue in the main pharmacy and cancer center since November 2017. A quote for the required scope of work (update HVAC unit that serves the mixing room) to correct the temperature and humidity issue was received on 12/5/17 and authorized on 3/20/18. Review of email correspondence dated 5/23/18 from the Interim Pharmacy Director to the Director of Facilities Management identified that humidity in the main pharmacy IV suite continues to rise, the room is now at 78% relative humidity and the floor and window panels are getting wet. The Executive Director identified the main pharmacy would need to close for approximately 6 weeks during this project hence has been delayed until a plan could be established to continue operations, however, until that time,				

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
Facilities staff should document interventions to address the elevated humidity levels. Facility documentation failed to consistently identify remediation when aware of such issues. Review of the Sterile Preparations; Viable and Non-Viable Environmental Monitoring Program policy directed that USP 797 has no specific requirement relative to humidity, however, suggested range of 25%-60% is best suited for sterile compounding suite to reduce infection control issues which can occur when floors and other surfaces become slick with moisture.				

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6) and/or (l) infection control (1).				
11. Based on a tour of the surgical department, review of facility policies, observations and interviews the facility failed to ensure proper hair coverage in the restricted surgical areas. The finding includes:	The Surgical Attire Policy was reviewed with OR staff via ongoing huddles and staff meetings.	Executive Director, Perioperative Services Chair, Department of Anesthesia	9/19/2018-ongoing	• Ten direct observational audits of compliance with OR Attire will be conducted to monitor compliance of proper surgical attire. After 3 months, the observations will be performed quarterly • All results will be reported out at the OR Committee meetings.
a. A tour of the surgical department was conducted on 8/29/18 with RN #2. Observations on 8/29/18 at 10:15 AM in OR (operating room/restricted area) #2 noted that MD #1 (Anesthesiologist) had donned a face mask, had a full beard and facial hair was not completely contained during the surgical procedure. Interview with RN #2 (Nurse Educator) at this time indicated that the facility had two	OR staff was educated as to the requirements for the donning of beard covering with surgical caps at all points of entry into the restricted area of the operating room. A Practice Alert regarding surgical attire was created	Nurse Educator Executive Director, Nurse Educator	9/19/2018 10/24/2018	

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
different types of facial covers that could be used to cover all facial hair. Observation in OR #1 at 10:20 AM identified the circulator nurse had donned a bouffant hair covering and hair was not fully contained beneath the head covering at the top and sides of the head. Interview with RN #2 on 8/15/18 at 10:20 AM indicated that the facility followed AORN (Association of periOperative Registered Nurses) guidelines for surgical attire. The facility policy for surgical attire in the OR identified that head and facial hair including sideburns and neckline is covered when in the semi restricted and restricted areas. Surgical head covering must confine hair and completely cover ears, scalp skin, sideburns and nape of the neck.	and posted in HealthStream for all nursing staff with a completion date of November 2, 2018. The Surgical Attire Policy was modified to incorporate more definitive language regarding hair covering and cover jackets.	Executive Director, Nurse Educator, Chief of Surgery, Chair, Department of Anesthesia	10/24/2018	

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
12. Based on a tour of the CSD (central sterile department), review of facility documentation and interviews the facility failed to provide documentation that high level disinfecting equipment was maintained. The finding includes: a. A tour of the CSP (central sterile processing) department was conducted with the CSP Manager on 8/29/18. Observation on 8/29/18 at 11:40 am identified that the facility had a "Medivators" scope cleaner to perform high level disinfection for endoscopes. Review of the "Medivators" filter change log indicated that the right and left basin drain filters were last changed on 3/16/18. Interview with the Certified Scope Technician on 8/29/18 at 11:40 am noted that the "Facilities" department was responsible to change filters and the filters were changed last week. Further review of the filter change log with the CSD Manager on 8/29/18 at 11:43 AM noted that both the left and right basin drain filters were to be changed monthly	All filters were changed as per manufacturer's recommendation. A meeting was held with Facilities, Infection Control and Central Sterile Processing staff to develop a plan of correction. PM roles were delineated. A meeting was held with CSP and Facilities leadership to review the Medivator Log. The vendor was contacted and conducted two in-services in October for Facilities, IC and CSP staff. Central Sterile Processing created and updated the filter change and PM (Preventive Maintenance) sign off sheet.	Manager, Central Sterile Processing Director, Facilities	9/15/2018 10/12/2018 10/22/2018 10/24/2018 and 10/25/2018	• The Medivator Log will be completed and reviewed monthly by Facilities and Central Sterile processing leadership to ensure compliance with Medivator maintenance

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
as indicated on the log per manufacturer's recommendations. Based on a tour of the orthopedic/surgical unit, review of facility policy observation and interview, the facility failed to ensure that standard aseptic practices were followed for one of two observations of medication vial access. The finding includes: A tour of the 10th floor surgical unit was conducted on 8/30/18. Observation on 8/30/18 at 10:20 AM identified that RN #1 swabbed the outer septum of the insulin vial with an alcohol wipe, inserted the needle into the septum and drew up the medication into the syringe. Further observation identified that RN #1 then proceeded to open the vial of powdered medication (Protonix) and inserted the needleless syringe of normal saline into the vial septum without the benefit of first swabbing the septum with an alcohol wipe (70% alcohol). Interview with the Interim Director of the Medical/Surgical department on 8/30/18 at 10:35 AM indicated that all staff are taught to swab the vial septum with an alcohol wipe prior to access. The	A practice alert was sent to all registered nurses 9/14/18 emphasizing that upon initial use and any subsequent re use of medication vials the vial septum must first be swabbed with an alcohol wipe (70% alcohol) Medication administration policy updated to include following information regarding use medication vials "Medication vials are to be cleansed with alcohol prep at time of initial opening and every time thereafter."	Director of Professional Development	Practice alert 9/14/18 Medication Administration Policy revision 10/15/2018	• Monthly random audits of medication administration, specifically 10 direct observations on the Surgery Unit for three consecutive months. • Any deviations from practice will be address immediately. • Results of the audits will be sent to the Manager, Regulatory Affairs.

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
facility policy for medication administration lacked direction for the vial accessing procedure. According to APIC (Association for Professionals in Infection Control and Epidemiology), Safe Injection, Infusion, and Medication Vial Practices in Heath Care (2016); Disinfect the rubber stopper of medication vials with sterile 70% alcohol before inserting a needle and prior to access.				

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (d) Medical records (3) and/or (e) Nursing Services (1). 13. Based on medical record review, review of facility contracts and interviews for two of three patient anesthesia records reviewed (Patients #24 and #25), the anesthesia provider failed to document the IV (intravenous) accurately on the anesthesia flow record. The finding includes: a. Patient #24 had a gastroscopy with biopsy on 8/29/18. The preoperative and/or postoperative nursing documentation dated 8/29/18 identified that a left wrist IV was started and/or discontinued. Review of the Patient's record and interview with the Nurse Educator on 8/29/18 at 11:00 AM identified that the anesthesia record	Memo sent out to all anesthesia staff, informing them: IVs not placed by anesthesiologists should be documented as "IN SITU". This will prevent duplicate documentation. If you place an IV, you have to include site, gage and whomever placed the IV.	Chair, Department of Anesthesia	12/19/2018	Random audit of 5 charts/month for three consecutive months to ensure any IVs place by an anesthesia provider are being correctly documented. for compliance. Results of the audits will be reported out at the Anesthesia staff meetings.

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
incorrectly noted that P#24 had an IV that was located in the right hand. b. Patient #25 had a retrograde pyelogram cystoscopy on 8/29/18. The preoperative and/or postoperative nursing documentation dated 8/29/18 identified that a left forearm IV was started and/or discontinued. Review of the patient's record and interview with the Nurse Educator on 8/29/18 at 11:08 AM indicated that the anesthesia record incorrectly noted that P#25 had an IV that was located in the left antecubital area. The facility rules and regulations for the department of anesthesia identified that anesthesia care should be documented to reflect the pre- anesthesia, peri-anesthesia and post- anesthesia components.				

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (a) Physical plant and/or (b) Administration (2) and/or (c) Medical Staff (2) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (6). 14. Based on medical record review, review of facility policies, review of facility documentation review of personnel files, observations and interviews for one of three patients (P#5) who had an MRI (magnetic resonance imaging) the facility failed to ensure a safe environment. The finding includes: a. Patient #5 had an MRI of the brain ordered in the ED on 2/23/17 for complaint of temple pain and double vision. MRI documentation by MRI Tech #1 identified that the P#5 arrived at the MRI department on 2/23/17 at 5:30 PM and departed at 5:46 PM. Review of facility documentation dated 3/3/17	MRI staff re-educated regarding the following: • Leaving zone II internal door blinds open • While patient in zone II, face stretcher towards internal door; for patient safety, staff should be frequenting that area if occupied • Gently offer patients assistance in placing earplugs • Always give patients panic ball once in zone IV	Administrative Radiology Manager	3/7/17-3/17/17	Weekly observational audits were performed beginning in March 2017 to ensure that all measures for safe patient care were in in place and being followed. The weekly audits continue with 100 % compliance.

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
indicated that Patient #5 alleged that a "panic button" was not provided during the MRI, had to wait for transport staff in a small room (Zone 2) on the stretcher without a call bell, was not checked for 10 minutes and had to "shimmy off" the stretcher unassisted to get help to use a bathroom. Review of facility documentation dated 3/3/17 by P#1 noted that MRI Techs #1 and #2 did not provide assistance with transfer on and off the stretcher. Review of the personnel file of both MRI Tech #1 and #2 indicated that they were "Traveler Techs" and both were asked not to return to the hospital before their contract had ended. Observation of the Zone 2 MRI waiting area on 9/4/18 at 1:02 PM identified a small room, with a door to the MRI control room with door blinds open and a long-corded call bell was noted on the wall. Interview with the Radiology Manager on 9/5/18 at 1:03 PM noted that MRI Tech #2 was not interviewed as her contract was terminated on 2/24/17 and MRI Tech #1 did not recall Patient #5 or the event. The interview also identified that following Patient #5's complaint, a call bell was installed in the radiology waiting room, staff were educated to	Installed call box with long extension cord in zone II Painted zone II to create a more welcoming environment for patients and their family members Initial Hire Competency updated to include call bell orientation 7/2018 All staff attended customer service training addressing staff sensitivity to patient needs and perception of care. For annual reinforcement, created below annual competency evaluation for MRI staff: *Adhere to following guidelines for positive patient experience and safety:* • Provide call bell to any patient waiting in zone II. • Face stretcher towards zone III and keep blinds open.		3/16/17 4/2017 7/2/18-7/25/18 09/01/18-09/30/18 to be evaluated annually	

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
keep the blinds on the door to the control room opened and reeducated to provide patient with earplugs and panic ball for MRI testing. MRI Techs #1 and #2 were unavailable for interview at the time of the investigation. The facility MRI clinical competency included the provision of hearing protection ear plugs/headphones/call button. The facility employee code of conduct identified that employees are trained to carry out their work in a manner that is safe, in part, for the patients they serve.	• Offer assistance in transferring patients to MR table. • Set expectations (i.e. before transferring) and explain procedure. • Offer comfort measures when possible (i.e. warm blanket). • Provide assistance if needed, for ear plug placement. • Provide panic ball to all patients in zone IV.			

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (f) Diagnostic and therapeutic facilities and/or (i) General (6). 15. Based on medical record review, review of facility policies, review of facility documentation review of personnel files and interviews for one of three patients (Patient #5) who had had an MRI (magnetic resonance imaging), the facility failed to ensure that treatment was provided in a dignified manner. The finding includes: a. Patient #5 had an MRI of the brain ordered in the ED on 2/23/17 for complaint of temple pain and double vision. MRI documentation by MRI Tech #1 identified that Patient #5 arrived at the MRI department on 2/23/17 at 5:30	MRI staff re-educated regarding the following: • Leaving zone II internal door blinds open. • While patient in zone II, face stretcher towards internal door; for patient safety, staff should be frequenting that area if occupied. • Gently offer patients assistance in placing earplugs. • Always give patients panic ball once in zone IV.	Administrative Radiology Manager	3/7/17-3/17/17	• Weekly observational audits were performed beginning in March 2017 to ensure that all measures are in place and that all patients are being treated in a dignified manner. • The weekly audits continue with 100 % compliance. • Any MRI complaints are immediately communicated to Radiology Leadership.

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
PM and departed at 5:46 PM. Review of facility documentation dated 3/3/17 indicated that Patient #5 alleged having to hear vulgar language between MRI Techs #1 and #2 on 2/23/17. The facility documentation dated 3/3/17 by Patient #1 noted that MRI Techs #1 and #2 did not explain the MRI procedure prior to the test, did not provide assistance with transfer on and off the stretcher and roughly assisted with earplug placement. Review of the personnel files noted that both MRI Tech 31 and #2 were "Traveler Techs" and both were asked not to return to the hospital before their contract had ended. Observation of the Zone 2 MRI waiting area on 9/4/18 at 1:02 PM identified a small room, with a door to the MRI control room with door blinds open and a long-corded call bell was noted on the wall. Interview with the Radiology Manager on 9/5/18 at 1:03 PM noted that MRI Tech #2 was unable to be interview at the time of the complaint and MRI Tech did not recall Patient #5 or the event. The interview also identified that following Patient #5's complaint education regarding proper staff to patient approach was also provided to staff. MRI Techs #1 and #2 were unavailable for interview at	Installed call box with long extension cord in zone II. Painted zone II to create a more welcoming environment for patients and their family members. Initial Hire Competency updated to include call bell orientation.7/2018. All staff attended customer service training addressing staff sensitivity to patient needs and perception of care. For annual reinforcement, created below annual competency evaluation for MRI staff: *Adhere to following guidelines for positive patient experience and safety:* • Provide call bell to any patient waiting in zone II. • Face stretcher towards zone III and keep blinds open.		3/16/17 4/17 7/2/18-7/25/18 09/01/18-09/30/18 to be evaluated annually	

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
the time of the investigation. The facility patient rights and responsibilities policy identified a right to be treated with respect. The facility employee code of conduct identified that each patient should be respected with their needs and desires considered.	• Offer assistance in transferring patients to MR table. • Set expectations (i.e. before transferring) and explain procedure e. Offer comfort measures when possible (i.e. warm blanket). • Provide assistance if needed, for ear plug placement. • Provide panic ball to all patients in zone IV.			

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (e) Nursing Services (1) and/or (i) General (6). 16. Based on medical record review, review of facility documentation and interviews for one of six patients (Patient #8) who had hypertension, the facility failed to ensure that the automatic BP (blood pressure) cuff did not inflict pain on the patient. The finding includes: a. Patient #8 had a history of hypertension and had spinal surgery of the cervical and thoracic spine on 12/18/17. Review of progress notes dated 12/20/17 identified that the patient had improved right hand weakness and slight weakness of right hand grasp when compared to the left. Review of vital	The Nurse Manager (NM) spoke with personnel involved. The Certified Nurse Assistant (CA) did not recall the complaint but when the NM asked her to describe the steps she would take if a patient complained about a BP cuff being too tight the CA was able to articulate the proper procedure which included removing the cuff, notify the RN and use a manual BP for any further BP readings.	Nurse Manager, General Surgery/Orthopedics	12/2017	• All CAs will continue to receive annual education which includes vital sign taking with a specific reference as what to do if the patient complains that BP cuff is too tight. • Any further complaints will be brought to the Nurse Manager for immediate review. • No other complaints have been received regarding pain from BP cuffs since this complaint 1 year ago.

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
sign records dated 12/21/17 at 12:32 AM indicated that the Patient's BP was 162/66 (normal= 95-140/60-90) and was taken by CNA #1 on the right arm. Vital sign records dated 12/21/17 at 5:20 AM noted that the Patient's BP was 185/73 and was documented by RN #11. Review of nursing narratives by RN #11 dated 12/21/17 identified that Patient #8 complained of severe left arm pain when CNA #1 took his/her BP at 4:00 AM and had to be given an analgesic and reassurance. The medication record indicated that Tramadol 50mg was administered to the Patient at 4:06 AM for complaint of level "5" (moderate) left arm pain. Interview with NA #1 on 9/11/18 at 7:36 AM noted that she did not recall the incident but, recalled being questioned by her Manager about the incident a month or two after the incident. NA#1 further identified that if a BP cuff was too tight, she may then take the BP on the opposite arm. Interview with RN #11 on 9/13/18 at 7:44 AM indicated that Patient #1 complained of left arm pain after CNA #1 took the Patient's BP, assessed the Patient and administered medication for pain. Review of office notes and interview	The NM also spoke with RN involved. RN did reassess the pain after administration of pain medication as per policy. NM also contacted clinical engineering after the complaint to see if the machines are calibrated differently causing some cuffs to inflate more than others Per clinical engineering machine, all BP machines are calibrated the same. NM reviewed the case at the am unit huddle and at a unit staff meeting following the complaint. All Certified Nursing Assistants on the unit will continue to receive annual education during Competency Day which that includes vital sign education. At the December 28, 2018 unit staff meeting, the case and proper procedure for when a patient complains of pain due	Director of Professional Development Nursing Manager	12/28/18	

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
with MD #11 on 9/5/18 at 1:32 PM identified that Patient #8 had some left-hand weakness prior to 12/18/17, the tightened BP cuff could have contributed to the neuropathy but, the neuropathy was multifactorial to include carpal tunnel syndrome.	to tightness of BP cuff will be reviewed.			

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (b) Administration (2) and/or (c) Medical Staff (2) and/or (d) Medical records (3) and/or (i) General (6). 17. Based on medical record review, review of facility policies and interviews for one of three patients who had a cardio-pulmonary event (Patient #6), the facility failed to ensure that the advanced directive information was accurate. The finding includes: a. Patient #6 was admitted to the hospital on 1/22/17 and was diagnosed with dehydration and altered mental status. The H&P (history and physical) identified that Person #3 was the POA (power of attorney), could not be reached and "son" (Person #2) was unsure of the Patient's code status. Patient #6 remained full code status and was discharged to home on 1/27/17. b. Patient #6 was 95y/o and was admitted to the hospital with altered	At the January 2019 hospitalist meeting the finding will be presented to the department providers. On December 18, 2018, The Hospitalist Director sent the organization's "Do Not Resuscitate Order" policy to the practitioners within the Hospitalist Department to review with a sign off. The Hospitalist Director discussed the finding with the physician involved.	Physician Director, Hospitalist Department.	1/2019 12/18/18 9/10/18	• The Hospitalist Department will audit 5 charts per month for three consecutive months of patients with diminished capacity who have designated health care representatives and a "DNR" order was placed. • The chart audit will assess compliance with the "Do Not Resuscitate Order" policy. • Results of the audits will be presented at the Hospital Staff Meeting.

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
mental status on 2/7/17. Review of physician orders by MD #13 dated 2/7/17 at 5:04 PM directed Full Code. Physician orders by MD #13 dated 2/7/17 at 5:40 PM directed do not resuscitate-no compressions/no intubation. The H&P by MD #13 dated 2/7/17 indicted that Person #1 was unable to be reached, would get palliative care involved, DNR/DNI (do not intubate) and discussed with friend. The discharge summary by MD #13 dated 2/10/17 noted that case was discussed with Son, (was Patient's personal aide not son/Person #2), discharged (to home) on comfort measures and with hospice agency. c. Patient #6 was admitted via ambulance to the ED on 3/5/17 with unresponsiveness and was assessed by MD #15 at 5:36 PM. Review of the progress note by MD #15 dated 3/5/17 identified that the EMS (emergency medical service) report was not available at the time of the ED evaluation, Person #3 could not be reached and the recent medical record indicated DNR. Review of the progress note by MD #15 dated 3/5/17 noted that he was called to the bedside, Patient #6 was flat line on the monitor and given the recent DNR status				

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
on the recent admission, further resuscitation of this elderly patient in asystole, who is extremely unlikely to regain spontaneous circulation, seemed to be futile and extremely unlikely to result in a survival leading to hospital discharge. Further review of the progress note indicated that Patient #6 was pronounced dead at 4:26 PM. Interview with Person #3 on 9/10/18 at 12:49 PM noted that he/she was Patient #6's POA and had never consented to a DNR status for the patient. Further interview with Person #3 indicated that Patient #6's personal aide (Person #2), whom Patient #6 called "son", was also aware of Person #3's refusal to approve a DNR status for Patient #6. Interview with MD #13 on 9/10/18 at 1:32 PM identified that he did not recall how the DNR order came about because he did not document it. MD #13 further noted that he would of obtained the information from a prior order, or family. The facility DNR policy identified that if the patient has diminished or fluctuating capacity, efforts to determine the patient's wishes should be made to include advanced directives, any statement made by the patient to his				

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
attending physician and, if available, health care agent, next of kin, legal guardian or conservator. The policy further indicated that the physician should attempt to identify, consult with, the patient's health care agent, next- of- kin, legal guardian or conservator in an incapacitated patient with surrogates.				

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
The following are violations of the State of Connecticut Public Health Code Section 19-13-D3 Short Term Hospitals, General and Special (i) General (7): 18. Based on review of facility documentation, review of facility policies, and staff interviews and observation, the facility failed to maintain the environment: a. The Tully Center Facilities Director did not provide documentation to indicate that electrical receptacles throughout the facility in patient care rooms were being tested at intervals not exceeding 12 months-or at intervals defined by documented performance data, as required by section # 6.3.4.1.2 of NFPA 99,"Health Care Facilities", facility policies & procedures and as part of the facilities plan for upgrading utilities and equipment; i.e., inspection and testing documentation provide, dated 04/08/18, identified that ninety-five (95) electrical outlets failed the inspection and testing and the facility did not provide supporting documentation to indicate	Documentation of Electrical Receptacle Survey completion was requested and received. Electrical receptacle testing is conducted annually and documentation will be requested, delivered on time and reviewed by facilities Management. Any deficiencies will be addressed and reported. Annual inspection scheduled for 4/2019. The Electrical Receptacle Policy was reviewed in 12/2018 and will be discussed at the January	Facility Supervisor & Director of Facilities	Electrical receptacles were re tested and deficiencies were corrected on 9/8/18 9/17/18 4/2019 1/2019	• Electrical receptacle testing is conducted annually and documentation will be received, reviewed and maintained. The Tully Facilities Supervisor, the Director of Facilities and Facilities Compliance officer will audit the annual PM plug test results to ensure timely completion.

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
that failed outlets had been replacement and or repaired. b. The Tully Center Facilities Director did not provide documentation to indicate that the facility had established policies and protocols for the type of test and intervals of testing for patient care-related electrical equipment as required in NFPA 99 "Health Care Facilities". c. The Tully Center Facilities Director did not provide documentation to indicate that patient care-related electrical devices in-patient care areas were being inspected as required in NFPA 99 "Health Care Facilities". d. The Tully Center Facilities Director did not provide documentation to indicate that patient care-related electrical devices in-patient care areas had been tested and inspected before use and annually thereafter as required in NFPA 99, Section 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.3, 10.5.6, and 10.5.8; and as part of the facilities preventive maintenance program; i.e., facility and non-facility owned patient care-related equipment with the following inventory control number and/or serial number	2018 Facilities Staff Meeting.			

Violation Alleged	Risk Reduction Strategy	Person(s) Responsible for Implementation	Date of Implementation	Measurement Strategy
lacked supporting documentation that the equipment was ready for patient use: #0075-12059, #0075-09702, #0075-02996, #0075-9546, #0075-12059, #0075-12049 and G.E. beam light SN-E001752.				